DR. LISA GAMACHE
DR. NEHA DAS
BOARD CERTIFIED PEDIATRIC DENTISTS

BERKSHIRE PEDIATRIC DENTISTRY

77 Elm Street
Pittsfield, MA 01201
413-442-0122

Pt Name: _____ Date of Birth: _____

If your child has an Autism Spectrum Disorder, please help us make this the best experience possible for him/her by answering the following questions:

How would you describe your child's ASD: Mild Moderate Severe Don't Know

How does your child communicate?

- *Language understanding* Limited Some Most
- *Speech* Non-Verbal Limited Verbal Highly Verbal
- *Complies with simple instructions* Rarely Sometimes Usually

What activities can your child complete on their own:

Restroom Bathing Dressing Hair brushing Toothbrushing

Is your child sensitive to any of the following:

Loud Noises Bright Lights Unfamiliar smells Unfamiliar Tastes

What reward system works best for your child? _____

_____

Has your child had any negative experiences with a doctor or dentist: No Yes

If yes, please explain: _____

What can we do to make this visit easier for your child? _____

_____

Does your child express any concerns about aspects of his/her teeth or mouth? No Yes

If yes, please explain: _____

Is there anything else you would like us to know about your child? _____

_____

Thank you!